Danville Chiropractic: 1995 East Main Street, Danville, IN 46122 Phone: 317-745-5100

Name: _____ Date of Birth: _____/_____/_____

Nickname: _____Social Security #_____-_____-_____

Address: _____City:_____ State:_____ Zip:_____

E-mail address:_____ Age:_____ Marital: ☐ **M** ☐ **S** ☐ **W** ☐ **D**

Cell Phone: (_____)_____ Alt. Phone: (_____)_____ Circle Primary Phone

Occupation:_____ Employer:_____

Employer's Address:_____ Office Phone :_____

Spouse:_____ Occupation:_____ Employer:_____

How many children? _____Names and Ages of Children:_____

Emergency Contact:_____Phone:_____

Who may we thank for referring you in? _____

How did you hear about us? ☐ Referral ☐ Mail ☐ Facebook ☐ Google ☐ Location ☐ Insurance ☐ Walk-in ☐Other_____

Family Medical Doctor: _____ Telephone #_____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? ☐ Yes ☐ No

INSURANCE INFORMATION

Name of Primary Insurance Company: _____

Relationship to Primary insured: ☐ Self ☐ Spouse ☐ Child ☐ Step-Child ☐Other _____

Primary Insured Name: _____ Date of Birth: _____/_____/_____

Primary ID/Member Number:_____ Group #:_____

Name of Secondary Insurance Company (if any):_____

Relationship to Secondary insured: ☐ Self ☐ Spouse ☐ Child ☐ Step-Child ☐Other _____

Secondary Insured Name: _____ Date of Birth: _____/_____/_____

Secondary ID/Member Number: _____ Group #:_____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to Peak Health Chiropractic PC dba Danville Chiropractic. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. **In consideration of the services to be provided to the customer/patient, I/we hereby guarantee payment in full of the customer's account in accordance with the financial arrangements made at the time of service/purchase or, if no such arrangements are made, in event of default in payment, reasonable collection agency fees equal to thirty (30%) percent of the delinquent balance and reasonable attorney fees, shall be added to the amount due to the account, plus any applicable court costs. You expressly consent and agree to Peak Health Chiropractic PC, dba Danville Chiropractic and their affiliates, agents and service providers may use written, electronic and verbal means to contact you. This consent includes but is not limited to, contact by manual methods, prerecorded or artificial voice messages, text messages, emails, and/or automatic telephone dialing systems. You agree that Peak Health Chiropractic PC dba Danville Chiropractic and their affiliates, agents and service providers may use any email address or telephone number you provide, now and in the future, including a number for cellular phone or other wireless device, regardless of whether you incur charges as a result. PLEASE NOTE: P**ayment is due in full at the time of service. **We DO accept insurance assignment, but NOT until we are able to contract your insurance carrier directly to verify benefits which is not a guarantee of payment.** The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you want to receive your medical records, please inform our office.

Patient's/Guardian's Signature: _____ Date: _____/_____/_____

Name: _____ Date of Birth: _____/_____/_____

PAST MEDICAL HISTORY

Have you ever been diagnosed as having or have suffered from? (Place a check mark by conditions that apply to you)

☐ Broken or Fractured Bones	☐ Osteoarthritis	☐ Eating Disorder	☐ High/Low Blood Pressure
☐ Circulatory Problems	☐ Epilepsy	☐ Alcoholism	☐ Coughing Blood
☐ Rheumatoid Arthritis	☐ Pace Maker	☐ Drug Addiction	☐ Ulcers
☐ Seizures/Convulsions	☐ Strokes	☐ HIV Positive	☐ Depression
☐ A Congenital Disease	☐ Cancer	☐ Gall Bladder	☐ Ruptures
☐ Excessive Bleeding	☐ Heart conditions	☐ Other:_____	

Do you have a history of stroke ☐ Yes ☐ No **or** hypertension ☐ Yes ☐ No? _____

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? Women, please include information about childbirth (include dates): _____

_____

Have you been treated for any health condition by a physician in the last year? ☐ Yes ☐ No
If yes, describe:_____

What medications or drugs are you taking?_____

_____

Do you have any allergies to any medications? ☐ Yes ☐ No
If yes, describe: _____

Do you have any allergies of any kind? ☐ Yes ☐ No
If yes, describe: _____

Please list any other health problems you have, no matter how insignificant they may be:

_____

(Please use back of page for additional information)

SOCIAL HISTORY:

Do you drink alcoholic beverages? ☐ Yes ☐ No If so, how much per week?_____

Do you use any tobacco products? ☐ Yes ☐ No Do you smoke? ☐ Yes ☐ No If so, packs per day: _____

Do you take vitamin supplements? ☐ Yes ☐ No If so, please list:_____

Do you consume caffeine? ☐ Yes ☐ No If so, how much per day:_____

Do you exercise? ☐ Yes ☐ No If yes, what is the frequency and type of exercise?_____

What are your hobbies?_____

What percentage of time during the day (at home or at your job away from home) do you spend?
lifting_____% sitting_____% bending _____% working at a computer_____%

FAMILY HISTORY:

Father: ☐ living ☐ deceased Current age if still living:_____ Cause of death and age at death if deceased: _____ (check one)

Mother: ☐ living ☐ deceased Current age if still living:_____ Cause of death and age at death if deceased: _____ (check one)

Check if applicable to you: ☐ As an adopted child, little is known of birth parents or family.

Do you have any family members who suffer from the same condition you do? ☐ Yes ☐ No If so, please list:

_____

FAMILY DISEASES (check if applicable and indicate whether family member is **F**ather, **M**other, **S**ister, **B**rother, **C**hildren):

Tuberculosis	☐ M ☐ F ☐ B ☐ S ☐ C	Cancer	☐ M ☐ F ☐ B ☐ S ☐ C	Mental Illness	☐ M ☐ F ☐ B ☐ S ☐ C
Diabetes	☐ M ☐ F ☐ B ☐ S ☐ C	Asthma	☐ M ☐ F ☐ B ☐ S ☐ C	Heart Disease	☐ M ☐ F ☐ B ☐ S ☐ C
Stroke	☐ M ☐ F ☐ B ☐ S ☐ C	Kidney Disease	☐ M ☐ F ☐ B ☐ S ☐ C	Lung Disease	☐ M ☐ F ☐ B ☐ S ☐ C
Arthritis	☐ M ☐ F ☐ B ☐ S ☐ C	Liver Disease	☐ M ☐ F ☐ B ☐ S ☐ C	Headaches	☐ M ☐ F ☐ B ☐ S ☐ C
Back Problems	☐ M ☐ F ☐ B ☐ S ☐ C	Disc Problems	☐ M ☐ F ☐ B ☐ S ☐ C	Pinched Nerve	☐ M ☐ F ☐ B ☐ S ☐ C
Joint Problems	☐ M ☐ F ☐ B ☐ S ☐ C	Neck Problems	☐ M ☐ F ☐ B ☐ S ☐ C	Scoliosis	☐ M ☐ F ☐ B ☐ S ☐ C
		Multiple Sclerosis	☐ M ☐ F ☐ B ☐ S ☐ C	Bad Posture	☐ M ☐ F ☐ B ☐ S ☐ C

Other _____

Name: _____ Date of Birth: _____/_____/_____

SUMMARY

1. What is/are your major symptom/s? _____
2. What does this prevent you from doing or enjoying?_____
3. If this is a recurrence, when was the first time you noticed this problem?_____

   How did it originally occur?_____

   Has it become worse recently? ☐Yes ☐ No ☐ Same ☐ Better ☐ Gradually Worse

   If yes, when and how? _____
4. How frequent is the condition? ☐ Constant ☐ Frequent ☐ Occasionally ☐ Intermittent ☐ Night Only

   How long does it last? ☐ All Day ☐ Few Hours (range):_____ ☐ Minutes
5. Are there any other conditions or symptoms that may be related to your major symptom?

   ☐ Yes ☐ No If yes, describe: _____

   Are there other unrelated health problems? ☐Yes ☐ No. If yes, describe _____

   _____
6. Describe the pain: ☐ Sharp ☐ Dull ☐ Numbness ☐ Tingling ☐ Aching ☐ Burning ☐ Stabbing

   ☐ Radiating ☐ Other _____
7. Is there anything you can do to relieve the problem? ☐ Yes ☐ No. If yes, describe _____

   _____. If no, what have you tried to do that has not helped? _____

   _____
8. What makes the problem worse? ☐ Standing ☐ Sitting ☐ Lying ☐ Bending ☐ Lifting ☐ Twisting

   ☐ Other_____
9. List any **<u>major accidents or surgeries</u>** you have had other than those that might be mentioned above

   _____
10. **<u>WOMEN ONLY</u>**: Are you pregnant or is there any possibility you may be pregnant?

    ☐ Yes ☐ No ☐ Uncertain **First** Day of Last Menstrual Cycle:_____/_____/_____
11. Previous Chiropractic Experience ☐ Yes ☐ No Who?_____
12. Other Medical Professionals Seen for Condition_____
13. Notes: _____

_____

_____

_____

_____

_____

_____

Please rate yourself 1-10, 1 being no problems and 10 being the worst pain you can imagine.

NO SYMPTOMS ——————————————— EXTREME SYMPTOMS

☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** ☐ **8** ☐ **9** ☐ **10**